

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2014
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 4555 ELM ST NEWBURGH, IN 47630		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	<p>INITIAL COMMENTS</p> <p>This visit was for a recertification and state licensure survey.</p> <p>Dates of Survey: April 8, 9, 10, 2014</p> <p>Provider Number: 15G138 Aims Number: 100234400 Facility Number: 000675</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>Community Alternatives SW IN was found to be in compliance with 42 CFR, Part 483, Subpart I and 460 IAC 9 in regard to the recertification and state licensure survey. Quality Review completed 4/15/14 by Ruth Shackelford, QIDP.</p>	W 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.